Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: STEPHEN CARTER, MD 3100 TIMMONS LANE #250 HOUSTON, TX 77027	MFDR Tracking #: M4-10-3505-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TRAVELERS INDEMNITY CO Box #: 05	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier failed to properly pay this injured workers claim even after it was sent back as a request for reconsideration"

Amount in Dispute: $200.00

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier contends the Provider is not entitled to additional reimbursement."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
09/18/2009	99546 (CMS-1500 99456-W5-WP)	NA	$150.00	$0.00
09/18/2009	99080 (CMS-1500 99080-73)	NA	$25.00	$0.00
09/18/2009	99080 (CMS-1500 99080-69)	NA	$25.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided between March 1, 2008 and effective on date of service of this dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 12/18/2009

- FEES - W1 – WORKERS COMPENSATION STATE F/S ADJ. REIMBURSEMENT BASED ON MAX ALLOWABLE FEE FOR THIS PROC. BASED ON MEDICAL F/S/ OR IF ON IS NOT SPECIFIED, UCR FOR THIS ZIP CODE AREA.
- GL33 – B15 THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SVC/PROC BE RECEIVED AND COVERED. WORK-RELATED OR MEDICAL DISABILITY EVALUATION SERVICES (CPT 99455 OR 99456) SHOULD BE REPORTED WITH CODE 99080.

Explanation of benefits dated 03/19/10

- Z10F – 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY. AFTER CAREFULLY REVIEWING THE SUBMITTED INVOICE, ADDITIONAL REIMBURSE-MENT IS NOT JUSTIFIED.

- Z014 – 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCDURE. THIS PROCEDURE IS CONSIDERED INTEGRATED TO THE PRIMARY PROCEDURE BILLED.

Issues

1. Has Requestor billed for the CPT code 99456-W5-WP in accordance with 28 Tex. Admin. Code §134.204?
2. Is Requestor entitled to reimbursement per 28 Tex. Admin. Code §134.204?

Findings

1. The reimbursement for 99456-W5-WP is the MMI for **$350.00**. The body areas and/or conditions that are rated determine the impairment rating portion of reimbursement. Respondent reimbursed $800.00 for the CPT code 99546-W5-WP. There are three body areas per the diagnoses codes 959.5 INJURY OTHER AND UNSPECIFIED FINGER, 847.1 THORACIC SPRAIN AND STRAIN and 959.1 OTHER INJURY OF CHEST WALL. These correspond to the narrative's description of the injuries to the chest, upper back, and right hand/fingers. The narrative report lists a Cervical Spine and a Thoracic Spine DRE Category I counted as one body area, reimbursed at **$150.00**. The upper extremity right thumb range of motion was reimbursed at **$300.00**. The chest which was rated with a 0% impairment rating. However, there is no documentation as to the methodology used for this rating, hence no additional reimbursement is recommended. The MAR for 99456-W5-WP of $800.00 has been reimbursed and no additional reimbursement is recommended per 28 Tex. Admin. Code §134.204.
2. The report services billed under CPT code 99080-73 Work Status Report and CPT code 99080-69 Report of Medical Evaluation charge are global as preparation and submission of reports per 28 Tex. Admin. Code §134.204(j)(1)(d), therefore, no reimbursement is due for this service.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that any reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	**01/20/2011** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.